capital, etc., used to provide SNF services. While several commenters pointed to the large growth in per diem SNF costs between 1995 and 1998 (as indicated on SNF cost report data) as evidence that the SNF market basket was inaccurate, we wish to emphasize that we do not consider reported historical per diem SNF costs an appropriate benchmark for determining its accuracy. The SNF market basket index, like the market basket indices used for other Medicare payment systems, measures pure price changes of inputs associated with the efficient delivery of care. It should not reflect changes in historical reported SNF costs associated with inefficient care or medically unnecessary services. Suggestions that it should are antithetical to the very notion of a PPS. It should also not reflect changes in non-price factors, such as adding staff or purchasing additional supplies. In any event, the statute provides that, once the initial PPS rates have been established, the unadjusted payment rates for a given year are calculated by applying an update to the rates for the previous year; the statute does not provide for a complete recalculation of the rates by applying a revised market basket methodology retroactively to 1995.

It is also important to note that the statute itself sets forth a fairly prescriptive methodology for calculating and updating the initial per diem payments established under the SNF PPS in 1998. The statute requires the use of an FY 1995 base year to calculate the Federal rates, and the statute specifies the amount of the updates to the base year costs (market basket minus one). It further reduces the base year cost pool by eliminating the costs associated with atypical services exceptions and exemptions (under § 413.30 of the regulations), and sets the base payments at just above the freestanding mean. The current SNF PPS per diem payment rates reflect the methodology prescribed by statute, an intended consequence of which was the accumulation of budgetary savings. Thus, concerns regarding the level of funding associated with the base payment rates may actually have more to do with the statutory formula for establishing the payments than the market basket used to update them.

With regard to the weights used to allocate many of the price proxies within the market basket, these are based on 1992 data because these are the latest complete data available from the Bureau of the Census and the Bureau of Economic Analysis. When more recent data become available, we will review the data and determine whether to rebase the market basket index to a more recent year. However, previous experience has shown that there is very little impact in the overall percent change in the market basket index when it is rebased. This was shown in the May 12, 1998 **Federal Register** (63 FR 26292), when the SNF market basket index was last rebased to a 1992 base from a 1977 base.

All of the price proxies used in the calculation of the SNF market basket are based on the latest data released by their respective data sources. Therefore, the price proxies capture all of the dynamic price change which occurred or is expected to occur in any given period.

In response to the specific comment concerning the labor portion of the market basket, the labor input proxies used in the SNF market basket are based the Employment Cost Index, a proven national survey of wages, salaries, and benefits for nursing home and personal care facilities, published by the BLS. These measures are based on a fixed skill mix of workers and do not reflect changes in skill mix. They measure only actual changes in the wages of workers and not shifts in wage costs caused by a shift in the skill mix of workers used. This makes it the preferred proxy to use, since it measures only pure price changes and not changes caused by other factors.

As has always been our policy, we will continue to monitor and respond to any changes in the market for SNF services that affect the SNF market basket index. When data from the first fiscal year after full implementation of the SNF PPS become available, we plan to review the SNF market basket index to ensure that it accurately and appropriately captures all price changes faced by SNFs in providing services. This review includes updating weights used in allocating the price proxies within the market basket, as well as ensuring that our price proxies reflect market trends. For example, we monitor the proxy for prescription drugs to make sure that it reflects the price changes associated with both new and older medications.

Finally, HCFA and MedPAC recognize that the SNF input price index developed by HCFA is only one component of the change in SNF cost per day. The index is designed to capture only the pure price change of inputs used to produce a constant quantity and quality of care in a SNF. This is consistent with the definition as it is used by HCFA and MedPAC in the existing payment methodologies for SNFs, hospitals, home health agencies, and other settings.

Other factors in addition to input prices help determine the overall change in costs per day. These factors include changes in case-mix, intensity, and productivity. Under the inpatient hospital PPS, HCFA and MedPAC use an update framework to account for these other factors and to make annual recommendations to Congress on the magnitude of the update. HCFA and MedPAC are both exploring the possibility of developing a SNF PPS update framework to make similar annual recommendations to Congress. As part of this update framework, we would address non-market basket factors such as intensity, productivity, and changes in site of service. This would allow us to maintain the integrity (and stability) of the market basket by keeping it separate and distinct from these other factors.

It is very important to note that the non-market basket factors can be negative as well as positive. As SNFs move from a cost-based system to a fixed price PPS, there are likely to be substantial decreases in cost per unit of service. Increases in productivity, changes in site of service, elimination of ineffective practice patterns, and renegotiation to lower price contracts for inputs are some of the behavioral changes which result in negative factors.

1. Facility-Specific Rate Update Factor

Under section 1888(e)(3)(D)(i) of the Act, for the facility-specific portion of the SNF PPS rate, we will update a facility's base year costs up to the corresponding cost reporting period beginning October 1, 2000, and ending September 30, 2001, by the SNF market basket percentage. We took the following steps to develop the 12-month cost reporting period facility-specific rate update factors shown in Table 10.C.

TABLE 10.C.—UPDATE FACTORS [1] FOR FACILITY-SPECIFIC PORTION OF THE SNF PPS RATES—ADJUST TO 12-MONTH COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2000 AND BEFORE OCTOBER 1, 2001 FROM COST REPORTING PERIODS BEGINNING IN FY 1995

[Base year]

If 12-month cost reporting period in initial period begins:	Adjust from 12-month cost reporting period in base year that begins:	Using update factor of:
October 1, 2000	October 1, 1994	1.14457
November 1, 2000	November 1, 1994	1.14475
December 1, 2000	December 1, 1994	1.14494
January 1, 2001	January 1, 1995	1.14522
February 1, 2001	February 1, 1995	1.14567
March 1, 2001	March 1, 1995	1.14630
April 1, 2001	April 1, 1995	1.14693
May 1, 2001	May 1, 1995	1.14739
June 1, 2001	June 1, 1995	1.14768
July 1, 2001	July 1, 1995	1.14797
August 1, 2001	August 1, 1995	1.14843
September 1, 2001	September 1, 1995	1.14905

[1] Source: Standard & Poor's DRI HCC, 2nd QTR 2000; @USSIM/TRENDLONG0500@CISSIM/TRENDLONG0500.

For the facility rate, we developed factors to inflate data from cost reporting periods beginning October 1, 1994, through September 30, 1995, to the corresponding cost reporting period beginning in FY 2001. According to section 1888(e)(3)(D) of the Act, the years through FY 1999 were inflated at a rate of market basket minus 1 percentage point, while FY 2000 and FY 2001 are to be inflated at the full market basket rate of increase.

2. Federal Rate Update Factor

To update each facility's costs up to the common period, we:

A. Determined the total growth from the average market basket level for the period of October 1, 1999, through September 30, 2000, to the average market basket level for the period of October 1, 2000, through September 30, 2001.

B. Calculated the rate of growth between the midpoints of the two periods.

C. Calculated the annual average rate of growth for number 2, above.

D. Subtracted 1 percentage point from this annual average rate of growth.

E. Using the annual average minus 1 percentage point rate of growth, determined the cumulative growth between the midpoints of the two periods specified above.

This revised update factor was used to compute the Federal portion of the SNF PPS rate shown in Tables 1 and 2.

H. Consolidated Billing

The consolidated billing requirement places with the SNF itself the Medicare billing responsibility for virtually all of the services that an SNF resident receives. The original SNF PPS legislation in the BBA identified several service categories that were excluded from the SNF consolidated billing requirement, as well as from the bundled Part A payment made under the SNF PPS itself. As noted in the proposed rule, section 103(a) of the BBRA amended section 1888(e)(2)(A) of the Act, effective with services furnished on or after April 1, 2000, to exclude certain additional types of services from the consolidated billing requirement, thus allowing these services to be billed separately to Part B. We listed these excluded services, by HCPCS code, in Program Memorandum AB–00–18 (March 2000). Section 103(b) of the BBRA also amended section 1888(e)(4)(G) of the Act to provide for a corresponding proportional reduction in Part A SNF payments, beginning with FY 2001.

Comment: In addition to identifying certain individual services (within a number of broader service categories) for exclusion from the consolidated billing requirement, section 103 of the BBRA also gives the Secretary the authority to designate additional services within each of those categories for exclusion from this requirement. A number of commenters recommended that we exercise this authority to designate a variety of additional services for exclusion, such as modified barium swallow, stress tests, hyperbaric oxygen treatment, doppler studies, nuclear medicine, orthotic devices, gastrointestinal procedures performed in endoscopy rooms, and outpatient surgery performed in hospital treatment rooms or ambulatory surgical centers. Alternatively, some commenters suggested that we could accomplish this result by adding these services to the existing exclusion list (in regulations at § 411.15(p)(3)(iii)) for certain high-intensity outpatient hospital services. Others expressed the view that this latter authority should not be limited to only those services that actually require the intensity of a hospital setting, but rather, should also encompass services furnished in other, nonhospital settings as well. As an example, they cited magnetic resonance imaging (MRIs) furnished in freestanding imaging centers, which may be cheaper and more accessible in certain particular localities than those furnished by hospitals.

Response: The BBRA's discretionary authority applies only to identifying additional excluded services *within* the particular categories that are specified in the legislation itself (that is, chemotherapy and its administration; radioisotope services; and, customized prosthetic devices) and not to other services that fall outside of those particular categories. Further, we are not exercising this discretionary authority at the present time, because we believe that the particular HCPCS codes identified in the BBRA represent the service exclusions within the specified categories that are appropriate under current circumstances. We note that language in the BBRA conference agreement requests the GAO to conduct a review of the appropriateness of the particular HCPCS codes that this legislation has designated for exclusion from consolidated billing. As we indicated in the proposed rule, we will carefully consider the GAO's findings when they become available, in order to determine whether further refinements in the codes identified on the exclusion list might be warranted.

Moreover, we believe that the comments advocating broader exclusions, beyond the particular services identified in the BBRA, may reflect a misunderstanding of the overall objective of the consolidated billing provision. We do not view the identification of new service categories for exclusion from this provision in terms of a process of continual expansion to encompass an ever-broadening array of excluded services. As we noted in the May 12, 1998 interim final rule (63 FR 26297), the fundamental purpose of the consolidated billing provision is ''* * * to make the SNF itself responsible for billing Medicare for essentially all of its residents' services, other than those identified in a small number of narrow and specifically delimited exclusions.'' This is consistent with the type of discretionary authority that the BBRA provided, which we regard as essentially affording the flexibility to revise the list of excluded codes in response to changes of major significance that may occur over time (for example, the development of new medical technologies or other advances in the state of medical practice).

Finally, regarding the comment on MRIs, we noted in the May 1998, interim final rule (63 FR 26298) that the exclusion of certain outpatient hospital services (in regulations at § 411.15(p)(3)(iii)) is targeted specifically at those services ''* * * that, under commonly accepted standards of medical practice, lie *exclusively* within the purview of hospitals * * *'' (emphasis added); that is, services which generally require the intensity of the hospital setting in order to be furnished safely and effectively. Thus, to the extent that advances in medical practice over time may make it feasible to perform such a service more widely in a less intensive, nonhospital setting, this would not argue in favor of unbundling the nonhospital performance of the service, but rather, of considering whether to rebundle the service entirely back to the SNF.

Comment: A number of commenters noted that the BBRA has now excluded from consolidated billing those ambulance services that are furnished in conjunction with dialysis services, and asked that we extend this exclusion to apply as well to those ambulance services furnished in conjunction with the other newly excluded service categories identified in the BBRA (chemotherapy, radioisotope, etc.). Some suggested that we could accomplish this by administratively expanding the existing exclusion of certain high-intensity outpatient hospital services (in regulations at § 411.15(p)(3)(iii)) to encompass these newly excluded services (which would, in turn, result in excluding the associated ambulance services as well). Another argued that since many ambulance services have already been excluded from consolidated billing, it would be less complicated from an administrative standpoint simply to establish a categorical exclusion for all ambulance services.

Response: We note that, prior to the BBRA's exclusion of dialysis-related ambulance services from consolidated billing, we received a number of similar recommendations to designate the statutorily-excluded category of dialysis services as also being one of the excluded outpatient hospital services under § 411.15(p)(3)(iii), as a means of permitting the associated ambulance transportation to be excluded as well. In response, we noted in the preamble to the July 30, 1999 final rule (64 FR 41673) that such a recommendation reflects

> * * * a misunderstanding of the underlying purpose of the outpatient hospital exclusion. This exclusion from consolidated billing does not serve as a mechanism for unbundling ambulance services per se. The * * * unbundling of ambulance services associated with * * * excluded outpatient hospital services occurs simply because the bundling of ambulance services is itself tied to a beneficiary's status as an SNF ''resident'' for consolidated billing purposes, which is suspended by the receipt of these excluded types of outpatient hospital services.

Further, while the statute itself excludes a number of service categories from the consolidated billing requirement—including services of physicians and certain other practitioners that are defined as being entirely outside the scope of the Part A SNF benefit (see sections 1861(h)(7) and 1861(b)(4) of the Act)—the receipt of such services offsite does not have the effect of ending a beneficiary's status as an SNF ''resident'' for consolidated billing purposes and, consequently, does not result in unbundling the associated ambulance transportation. Thus, unbundling the ambulance transportation that is associated with the statutorily-excluded types of chemotherapy services, radioisotope services, and customized prosthetic devices would require legislation to amend the law itself, like that which Congress enacted in section 103(a)(2) of the BBRA with respect to dialysis-related ambulance services. Similarly, establishing a categorical exclusion of all ambulance services whatsoever would also require legislation to amend the law.

Comment: A number of commenters raised issues regarding so-called ''Part B'' consolidated billing, in connection with services furnished to those beneficiaries in the SNF who are not in a covered Part A stay. (As we noted in the proposed rule, implementation of this aspect of consolidated billing has been delayed as a result of higher-priority systems renovations that had to be completed timely in order to achieve Year 2000 (Y2K) compliance.) Most of these commenters recommended extending the timeframe for implementation of Part B consolidated billing until after implementation of the PPS case-mix refinements set forth in the proposed rule, and a few even suggested reconsidering whether to implement this aspect of consolidated billing at all. One commenter suggested that bills for those types of items that are currently submitted to the Durable Medical Equipment Regional Carriers (DMERCs) should continue to be submitted to them under Part B consolidated billing, since the DMERCs have acquired specialized expertise in this area. Another recommended that HCFA should impose limitations on the amounts that suppliers can charge SNFs for Part B services.

Response: Since the law provides that consolidated billing applies to services furnished to a SNF ''resident'' (regardless of whether Medicare covers a particular resident's stay), we do not have the discretion simply to decline to implement this aspect of the provision. As we indicated in the July 30, 1999 final rule (64 FR 41671), once we have determined the specific implementation timeframe for this aspect of consolidated billing, we will provide at least 90 days' advance notice in the **Federal Register**. However, specific operational instructions (such as those describing the details of particular billing procedures) are beyond the scope of this final rule, and will be addressed instead in HCFA program issuances. With regard to the suggestion that we limit the amount a supplier can charge a SNF for its services, we note that the Medicare transaction for a service that is subject to consolidated billing is the one that takes place between the Medicare program and the SNF itself. As we pointed out in the July 1999 final rule (64 FR 41677), a SNF's relationship with its supplier under consolidated billing is essentially a private contractual matter, and the specific terms of the supplier's payment by the SNF must be arrived at through direct negotiations between the two parties themselves.

Comment: Under the current regulations at § 411.15(p)(3)(iv), a beneficiary's status as a SNF ''resident''

(for consolidated billing purposes) generally ends at the point of departure from the SNF. However, if the beneficiary returns to that or another SNF within 24 hours of departure, the beneficiary's status as a ''resident'' of the SNF from which he or she departed would continue during the absence, along with that SNF's consolidated billing responsibilities. As we noted in the proposed rule, since consolidated billing is currently in effect only for those SNF stays that are covered by Part A and paid by the PPS, this means in actual practice that such a beneficiary remains a SNF ''resident'' after leaving the SNF only if he or she then returns to the SNF by midnight. (This is because, under longstanding Medicare policy, a beneficiary generally must be present in the SNF at midnight of a given day in order for that day to be considered a Part A day.) We then proposed to revise the regulations to adopt this ''midnight rule'' in place of the current ''24-hour rule,'' which would essentially extend the policy currently in effect under Part A consolidated billing to apply to Part B consolidated billing as well. The commenters overwhelmingly supported this proposal, indicating that the resulting uniformity in policy would reduce the potential for confusion and billing errors. One commenter, while supporting the idea of following a uniform policy for both aspects of consolidated billing, suggested that the policy should be the ''24-hour rule'' that currently appears in the regulations rather than the ''midnight rule.'' The commenter cited, as a reason for taking this position, a concern over whether Part A payment under the SNF PPS recognizes those services that are furnished on the day of a beneficiary's discharge from the SNF, but before the actual moment of departure.

Response: As recommended by the majority of commenters, we are revising the regulations to adopt the ''midnight rule.'' Thus, a beneficiary's status as a SNF ''resident'' for consolidated billing purposes ends upon departure, unless the beneficiary returns to that or another SNF by midnight of the day of departure. (As we explained in the proposed rule, a patient ''day'' begins at 12:01 A.M. and ends the following midnight, so that the phrase ''midnight of the day of departure'' refers to the midnight that immediately follows the actual moment of departure, rather than to the midnight that immediately precedes it.) With regard to the concern expressed by one commenter about services that are furnished on the day of (but before the actual moment of) discharge, we note that the SNF PPS does, in fact, recognize such services, as discussed below. Even though the day of discharge from a covered SNF stay is not itself a covered Part A day, under the pre-PPS (reasonable cost) SNF payment methodology, ancillary services furnished on that day but before the actual moment of departure were covered, included on the SNF's cost report, and reflected in final cost settlement. Accordingly, the cost of such services has been built into the SNF PPS base. This makes the PPS per diem amount somewhat higher than it would otherwise have been for all of the preceding SNF days that Part A *does* cover, even though the day of discharge itself is not a covered Part A day. Further, with regard to room and board, although the Medicare program uses a midnight-to-midnight approach as a convention for counting inpatient days, the routine costs for the covered day that immediately precedes the date of discharge would include (much like a hotel bill) the accommodations for that entire night.

Comment: In excluding the additional services from consolidated billing and the SNF PPS (and, thus, qualifying them for separate payment under Part B), section 103 of the BBRA also mandated a corresponding proportional reduction in Part A SNF payments, beginning with FY 2001. We described our methodology for making this adjustment in the proposed rule (65 FR 19202), and indicated that we expected the amount of the adjustment to be minimal. However, due to the complexity of the process and the amount of time involved in completing it, we added that we would publish the actual adjusted rates themselves prospectively in the final rule. One commenter requested us to share the methodology that we actually used in making this adjustment. Another argued that the reduction in Part A payment essentially cancels out the fiscal relief provided by allowing the newly-excluded services to be billed to Part B.

Response: Regarding our adjustment methodology, we have computed a reduction of 5 cents ($0.05) in the unadjusted urban and rural rates, using the identical data as used to establish the Part B add-on for a sample of approximately 1,500 SNFs from the 1995 base period. By matching the excluded codes specified in section 103 of the BBRA to the Part B bills, we identified an amount equal to a reduction of $0.05 in the Federal rate. While the amount of the reduction reflects those excluded codes that we were specifically able to identify, there may be additional excluded services that were not captured, since certain of these services were billed differently in 1995 than now, in a manner that may not have utilized the codes by which they were specified in the BBRA. We are, therefore, continuing to examine the billing practices in the PPS base year, and may revise our estimate of this reduction in the future to capture additional elements of allowable charges, as appropriate. Regarding the comment that characterized this adjustment as canceling out the fiscal relief that was otherwise provided by this section of the BBRA, we note that the reduction in Part A payment rates is specifically required by that same section of the law, in order to prevent the Medicare program from paying twice (once under Part A, and again under Part B) for the same service. Further, we believe that this comment may reflect a misunderstanding of the overall effect of this provision's fiscal relief. As amended by section 103(b) of the BBRA, section 1888(e)(4)(G)(iii) of the Act provides that the adjustment is to be made in such a way that the *aggregate* reduction in Part A payments is estimated to equal the *aggregate* increase in Part B payments attributable to the exclusion. Further, we note that the particular services were excluded in recognition that SNFs could experience ''* * * high-cost, low probability events that could have devastating financial impacts because their costs far exceed'' an individual SNF's PPS payment (H.R. Conf. Rep. No. 106–479 at 854). Thus, the actual result of this provision's mandatory Part A payment reduction is to take the expense of the excluded items (which could be financially devastating to an individual SNF that actually incurs it, if borne solely by that particular facility) and effectively redistribute it over the entire universe of providers. In much the same way that an insurance pool reduces the degree of financial risk to an individual member of the pool in the event of a catastrophic loss, effectively spreading the expense of the excluded items over such a large provider population helps minimize the potential financial liability that any individual provider might otherwise incur.

I. Appeal Rights

In the proposed rule, we discussed the appeal rights of SNFs to appeal their payment rates under SNF PPS. We received no comments on this discussion.

J. Impact Analysis of the Proposed Rule

As required by Executive Order 12866, the Unfunded Mandates Reform Act of 1995 (UMRA, Public Law 104–4),

and the Regulatory Flexibility Act (RFA, Public Law 96–354), the proposed rule included a Regulatory Impact Statement, on which we received comments. (A regulatory impact analysis for this final rule appears in Section VI. below.)

Comment: Several commenters alleged that there is a large variance between the projections for FY 2001, including the 20 percent add-on, and the most recent actual SNF program expenditure data. Some added that the Congressional Budget Office (CBO) baseline spending estimates differ from HCFA's. They noted that changes in rates due to inflation updates and statutory amendments do not necessarily account for the variance between FY 1999 and FY 2001. The commenters requested clarification of our projections and fiscal impacts, including any assumptions about volume growth or behavioral changes in response to payment changes.

Response: We have, in the past, included a behavioral offset in estimates required by legislation; however, we do not include them in estimating the effects of regulations merely for purposes of routinely updating the rates. The calculation of $1 billion for the 20 percent add-on assumes a baseline for FY 2001 of $15.3 billion. Our estimate of the days covered by the 20 percent add-on is 43 percent and our estimate of the Federal portion of payments is 85 percent. We note that CBO's baseline spending estimates differ from HCFA's due to different assumptions about SNF utilization patterns. Further, since the time we did these estimates, we have in fact reduced our own baseline estimate for FY 2001 to $14.4 billion, which still yields $1 billion in the calculation. However, we have since revised our estimate to reflect the latest available SNF data, as indicated in the impact analysis for this final rule (see section VI., below).

Comment: There were a number of comments expressing concern over the financial viability of providers. In particular, commenters were concerned with the number of nursing home chains that have filed for bankruptcy nationwide.

Response: We are aware of the challenges that certain providers have faced in moving from a payment system that was based on reasonable costs to a PPS, which uses mean-based prices. One of the intended consequences of the BBA was an overall reduction in SNF payments. However, we do not agree that the changes introduced by the SNF PPS are the exclusive—or even the primary—cause of their current financial difficulties. We believe that many of these financial constraints are directly attributable to business decisions on the part of the providers themselves. For example, a GAO review (''Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments but Maintain Access,'' GAO/HEHS–00–23, December 1999) of two of the largest publicly held chains found that the financial position of both firms suffered from high capital-related costs; substantial, non-recurring expenses and write-offs; and reduced demand for ancillary services related to several of the other BBA provisions. In fact, in one of these chains, SNF operations themselves remained profitable after the introduction of the SNF PPS. This scenario is consistent with reports of other chains experiencing financial difficulties. In addition, media reports cite rapid expansion into other lines of business, high capital costs, and inadequate cost controls as other factors influencing current financial status within the SNF industry.

IV. Provisions of the Final Regulations

The provisions of this final rule restate the provisions of the April 10, 2000, proposed rule as discussed previously and a minor technical correction of a cross-reference in parts 413 and 489. Following is a highlight of the changes made:

- In § 411.15, paragraph (p)(2)(vii) is revised to exclude from consolidated billing those ambulance services that are furnished to a SNF resident in conjunction with dialysis services that are covered under Part B.
- In § 411.15, paragraph (p)(2) is also revised to list the additional services that section 103 of the BBRA has excluded from consolidated billing.
- In § 411.15, paragraph (p)(3)(iv), the phrase ''within 24 consecutive hours'' is revised to read ''by midnight of the day of departure''.
- In § 413.1, paragraph (b), the phrase ''paragraphs (c) through (f) of this section'' is revised to read ''paragraphs (c) through (h) of this section'', in order to reflect previous revisions to this section that provide for prospective payment to SNFs (63 FR 26309, May 12, 1998) and home health agencies (65 FR 41211, July 3, 2000).
- In § 489.20, paragraph (s) is revised to list the additional services that the BBRA has excluded from consolidated billing, and a conforming change is made at § 489.21(h) regarding a cross-reference to this list.
- In § 489.20, paragraph (s)(7) is revised to exclude from consolidated billing those ambulance services that are furnished to a SNF resident in conjunction with dialysis services that are covered under Part B.
- Sections 489.20(s)(11) and 411.15(p)(2)(xi) are revised to reflect editorial revisions in the paragraphs concerning the transportation costs of electrocardiogram equipment.

V. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

VI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order (EO) 12866, the Unfunded Mandates Reform Act (UMRA) (Public Law 104–4), the Regulatory Flexibility Act (RFA) (Public Law 96–354), and the Federalism Executive Order (EO) 13132.

Executive Order 12866 directs agencies to assess costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). This final rule is a major rule as defined in Title 5, United States Code, section 804(2), because we estimate its impact will be to increase the payments to SNFs by approximately $3.1 billion in FY 2001. The update set forth in this final rule applies to payments in FY 2001. Accordingly, the analysis that follows describes the impact of this one year only. In accordance with the requirements of the Act, we will publish a notice for each subsequent FY that will provide for an update to the payment rates and include an associated impact analysis.

The UMRA also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure in any year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million or more in any given year. This rule will have no consequential effect on State, local, or tribal governments. We believe the private sector cost of this rule falls below these thresholds as well.

Executive Order 13132 (effective November 2, 1999), establishes certain

requirements that an agency must meet when it promulgates regulations that impose substantial direct compliance costs on State and local governments, preempt State law, or otherwise have Federalism implications. As stated above, this rule will have no consequential effect on State and local governments.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and governmental agencies. Most SNFs and most other providers and suppliers are small entities, either by virtue of their nonprofit status or by having revenues of $5 million or less annually. For purposes of the RFA, all States and tribal governments are not considered to be small entities, nor are intermediaries or carriers. Individuals and States are not included in the definition of a small entity. The policies contained in this rule would update the SNF PPS rates by increasing the payment rates published in the July 30, 1999 notice, but will not have a significant effect upon small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds. We are not preparing a rural impact statement since we have determined, and the Secretary certifies, that this notice will not have a significant economic impact on the operations of a substantial number of small rural hospitals.

A. Background

Section 1888(e) of the Act establishes the SNF PPS for the payment of Medicare SNF services for periods beginning on or after July 1, 1998. This section specifies that the base year cost data to be used for computing the RUG-III payment rates must be from FY 1995 (that is, October 1, 1994, through September 30, 1995.) In accordance with the statute, we also incorporated a number of elements into the SNF PPS, such as case-mix classification methodology, the MDS assessment schedule, a market basket index, a wage index, the urban and rural distinction used in the development or adjustment of the Federal rates, and other features.

This final rule sets forth updates of the SNF PPS rates contained in the April 10, 2000 proposed rule. Table 11 below, presents the projected effects of the policy changes in the SNF PPS from FY 2000 to FY 2001, as well as statutory changes effective for FY 2001 on SNFs. In so doing, we estimate the effects of each policy change by estimating payments while holding all other payment variables constant. We use the best data available, but we do not attempt to predict behavioral responses to our policy changes, and we do not make adjustments for future changes in such variables as days or case-mix.

This analysis incorporates the latest estimates of growth in service use and payments under the Medicare SNF benefit based on the latest available Medicare claims data and MDS 2.0 assessment data from 1999. Because we are not incorporating the refinements to the case-mix classification system, we are not presenting any additional information regarding their distributional impact on facility payments as we had indicated we would in the proposed rule. We note that certain events may combine to limit the scope or accuracy of our impact analysis, because such an analysis is future-oriented and, thus, very susceptible to forecasting errors due to other changes in the forecasted impact time period. Some examples of such possible events are newly legislated general Medicare program funding changes by the Congress, or changes specifically related to SNFs. In addition, changes to the Medicare program may continue to be made as a result of the BBA, BBRA, or new statutory provisions. Although these changes may not be specific to SNF PPS, the nature of the Medicare program is such that the changes may interact, and the complexity of the interaction of these changes could make it difficult to predict accurately the full scope of the impact upon SNFs.

B. Impact of This Final Rule

The purpose of this final rule is not to initiate significant policy changes with regard to the SNF PPS; rather, it is to respond to the comments on the proposed rule and establish the update methodology for FY 2001 after completion of our validation of the analysis presented in the proposed rule, based upon national data. Accordingly, we believe that the revisions and clarifications mentioned elsewhere in the preamble (for example, the update to the wage index used for adjusting the Federal rates) will have, at most, only a negligible overall effect upon the regulatory impact estimate specified in the proposed rule. As such, these revisions will not represent an additional burden to the industry.

As stated previously in this rule, the aggregate increase in payments associated with this final rule is estimated to be $3.1 billion. There are three areas of change that produce this increase for facilities—

1. The effect of the Federal transition, that results in many facilities being paid 75 percent at the Federal rate and 25 percent at the facility-specific rate instead of the current 50 percent Federal rate and 50 percent facility-specific rate. There is also the additional effect of the BBRA option to bypass the transition and be paid according to 100 percent of the Federal rate;

2. The implementation of various other provisions in the BBRA, such as the 20 percent and 4 percent add-ons to the Federal rates; and,

3. The total change in payments from FY 2000 levels to FY 2001 levels. This includes all of the previously noted changes in addition to the effect of the update to the rates.

As seen in Table 11 below, some of these areas result in increased aggregate payments and others tend to lower them. The breakdown of the various categories of data in the table are as follows:

The first row of the table describes the effects of the various policies on all facilities. The next six rows show the effects on facilities split by hospital-based, freestanding, urban and rural categories. The remainder of the table shows the effects on urban versus rural status by census region.

The second column in the table shows the number of facilities in the impact database. The third column shows the effect of the transition to the Federal rates. It includes the impact of the normal progression of facilities in the transition to new cost reporting periods and, therefore, blended payment amounts (that is, facility-specific versus Federal rates) as well as those facilities that, as a result of the BBRA, elect to bypass the transition and go immediately to the full Federal rate. This change has an overall effect of raising payments by 4.2 percent, with most of the increase coming from freestanding facilities. There are several regions that have decreased payments due to this provision, but the majority (and most populous) of the regions evidence higher payments, with the largest increase being in the New England and mid-Atlantic regions for both urban and rural facilities.

We estimate that approximately 63 percent of SNFs under the transition at the enactment of the BBRA have or will elect to be paid based on 100 percent of

the Federal rate. Of these facilities, we estimate 22 percent are hospital-based and 78 percent are freestanding, consistent with the proposed rule.

The fourth column shows the projected effect of the 4 percent add-on to the adjusted Federal rate mandated by the BBRA. As expected, this provision results in an increase in payments for all facilities. However, as seen in the table, the varying effect of the SNF PPS transition results in a distributional impact of this provision. In addition, since this increase only applies to the Federal portion of the payment rate, the effect on total expenditures is less than 4 percent.

The fifth column of the table shows the effect of the update to the Federal and facility-specific payment rates. It reflects an update to the Federal rates of 2.161 percent, which is equivalent to the market basket increase minus 1 percentage point, as required by law. In addition, it reflects an update to the facility-specific rates of 3.161 percent, which is equivalent to the full market basket increase for this period. For this analysis, it is assumed that payments will increase by 2.3 percent in total if there are no behavioral changes by the facilities. As can be seen from this table, the effects of the update itself do not vary significantly by specific types of providers or by location.

The sixth column of the table shows the effect of all of the revised wage index on the FY 2001 payments. The total impact of this change is 0 percent since the law requires this component of the update to be budget neutral. However, there are distributional effects of this change, as seen in the table.

The seventh column of the table indicates the overall impact of the 20 percent add-on for 15 specific RUG–III groups required under the BBRA.

Finally, the eighth column of the table shows the effect of all of the changes on the FY 2001 payments. This includes all of the previous changes, including the update to this year's payment rates by the market basket, and the 20 percent add-on. It is assumed that payments will increase by 21.8 percent in total, assuming facilities do not change their care delivery and billing practices in response. As can be seen from this table, the combined effects of all of the changes vary much more widely by specific types of providers and by location. For example, freestanding facilities enjoy more significant payment increases due to the policy changes, while the effects of the transition tend to diminish the increase for hospital-based providers.

TABLE 11.—PROJECTED IMPACT OF FY 2001 UPDATE TO THE SNF PPS

	Number of facilities	Transition to federal rates (percent)	Add on to Federal rates (percent)	Update change (percent)	Wage index change (percent)	20% add on (percent)	Total FY 2001 change (percent)
Total	9034	4.2	3.5	2.3	0.0	10.4	21.8
Urban	6300	3.6	3.5	2.3	−0.1	10.2	20.8
Rural	2737	7.1	3.7	2.2	0.8	11.3	27.3
Hospital based urban	683	−4.5	3.0	2.4	0.0	9.6	10.4
Freestanding urban	5617	5.1	3.6	2.3	−0.1	10.2	22.6
Hospital based rural	533	2.0	3.4	2.3	0.9	12.2	22.1
Freestanding rural	2204	8.2	3.7	2.2	0.7	11.1	28.3
Urban by region.							
New England	630	10.5	3.8	2.2	−0.8	10.9	29.0
Middle Atlantic	877	14.3	3.8	2.2	−0.3	12.9	36.5
South Atlantic	959	−0.4	3.3	2.3	−0.4	8.9	14.2
East North Central	1232	6.1	3.6	2.2	0.4	10.1	24.2
East South Central	212	1.9	3.5	2.3	−0.7	9.8	17.6
West North Central	469	3.6	3.5	2.3	0.4	10.2	21.4
West South Central	519	−5.2	3.0	2.4	1.0	8.8	9.9
Mountain	303	−4.0	3.1	2.4	0.0	7.1	8.5
Pacific	1070	−2.3	3.2	2.4	−0.5	9.6	12.6
Rural by region:							
New England	88	14.4	3.9	2.2	−0.9	12.6	35.6
Middle Atlantic	144	13.1	3.9	2.2	0.0	13.4	36.2
South Atlantic	373	5.3	3.6	2.2	1.1	11.1	25.2
East North Central	561	9.2	3.7	2.2	1.0	11.1	29.9
East South Central	255	4.2	3.6	2.3	0.6	12.3	24.8
West North Central	581	11.1	3.7	2.2	0.8	12.5	33.5
West South Central	354	1.2	3.4	2.3	1.1	9.8	18.8
Mountain	204	3.3	3.5	2.3	0.7	9.4	20.5
Pacific	151	3.2	3.5	2.3	0.3	9.2	19.7

While not specifically detailed in Table 11, we would also like to indicate the impact of the proportional reduction in the Federal rates to account for the new services excluded from consolidated billing (and, therefore, SNF PPS) under section 103 of the BBRA. The 5 cent ($0.05) reduction to the urban and rural unadjusted Federal rate results in an overall impact of a $2 million decrease in SNF payments for FY 2001.

Finally, in accordance with the provisions of Executive Order 12866, this notice was reviewed by the Office of Management and Budget.

VII. Federalism

We have reviewed this final rule under the threshold criteria of Executive Order 13132, Federalism, and we have determined that it does not significantly affect the rights, roles, and responsibilities of States.

List of Subjects

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

A. Part 411 is amended as set forth below:

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Exclusions and Exclusion of Particular Services

2. Section 411.15 is amended by:

A. Republishing the introductory text, and paragraph (p)(2) introductory text.

B. Revising paragraphs (p)(2)(vii) and (p)(2)(xi).

C. Adding new paragraphs (p)(2)(xii), (p)(2)(xiii), (p)(2)(xiv), and (p)(2)(xv).

D. Revising paragraph (p)(3)(iv).

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage.

* * * * *

(p) *Services furnished to SNF residents.*

* * * * *

(2) *Exceptions.* The following services are not excluded from coverage:

* * * * *

(vii) Dialysis services and supplies, as defined in section 1861(s)(2)(F) of the Act, and those ambulance services that are furnished in conjunction with them.

* * * * *

(xi) The transportation costs of electrocardiogram equipment (HCPCS code R0076), but only with respect to those electrocardiogram test services furnished during 1998.

(xii) Those chemotherapy items identified, as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600.

(xiii) Those chemotherapy administration services identified, as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542.

(xiv) Those radioisotope services identified, as of July 1, 1999, by HCPCS codes 79030–79440.

(xv) Those customized prosthetic devices (including artificial limbs and their components) identified, as of July 1, 1999, by HCPCS codes L5050–L5340; L5500–L5611; L5613–L5986; L5988; L6050–L6370; L6400–6880; L6920–L7274; and L7362–L7366, which are delivered for a resident's use during a stay in the SNF and intended to be used by the resident after discharge from the SNF.

(3) *SNF resident defined.* * * *

(iv) The beneficiary is formally discharged (or otherwise departs) from the SNF, unless the beneficiary is readmitted (or returns) to that or another SNF by midnight of the day of departure.

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END–STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

B. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395x(v)(1)(A), and 1395hh).

Subpart A—Introduction and General Rules

2. Section 413.1, paragraph (b), is amended by revising the phrase ''paragraphs (c) through (f) of this section'' to read ''paragraphs (c) through (h) of this section''.

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

C. Part 489 is amended to read as follows:

1. The authority citation for part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Essentials of Provider Agreements

2. Section 489.20 is amended by:

A. Republishing the introductory text and paragraph (s) introductory text.

B. Revising paragraphs (s)(7) and (s)(11).

C. Adding new paragraphs (s)(12), (s)(13), (s)(14), and (s)(15).

§ 489.20 Basic commitments.

The provider agrees to the following:

* * * * *

(s) In the case of an SNF, either to furnish directly or make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services furnished to a resident (as defined in § 411.15(p)(3) of this chapter) of the SNF, except the following:

* * * * *

(7) Dialysis services and supplies, as defined in section 1861(s)(2)(F) of the Act, and those ambulance services that are furnished in conjunction with them.

* * * * *

(11) The transportation costs of electrocardiogram equipment (HCPCS code R0076), but only with respect to those electrocardiogram test services furnished during 1998.

(12) Those chemotherapy items identified, as of July 1, 1999, by HCPCS codes J9000–J9020; J9040–J9151; J9170–J9185; J9200–J9201; J9206–J9208; J9211; J9230–J9245; and J9265–J9600.

(13) Those chemotherapy administration services identified, as of July 1, 1999, by HCPCS codes 36260–36262; 36489; 36530–36535; 36640; 36823; and 96405–96542.

(14) Those radioisotope services identified, as of July 1, 1999, by HCPCS codes 79030–79440.

(15) Those customized prosthetic devices (including artificial limbs and their components) identified, as of July 1, 1999, by HCPCS codes L5050–L5340; L5500–L5611; L5613–L5986; L5988; L6050–L6370; L6400–6880; L6920–L7274; and L7362–L7366, which are delivered for a resident's use during a stay in the SNF and intended to be used by the resident after discharge from the SNF.

§ 489.21 [Amended]

3. In § 489.21, paragraph (h), the phrase ''§ 489.20(s)(1) through (11)'' is revised to read ''§ 489.20(s)(1) through (15)''.

(Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance Program; and No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 18, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Approved: July 21, 2000.

Donna E. Shalala,

Secretary.

[FR Doc. 00–19004 Filed 7–25–00; 8:45 am]

BILLING CODE 4120–01–P